United States Senate
Committee on Finance
Washington, D.C. 20510-6200

Dear Colleagues of the Senate Finance Committee and the special Chronic Conditions Committee:

The Patient-centered Medical Home for Older Adults Network submits this set of suggestions in response to the Committee's request for reforms to Medicare that would improve care coordination, streamline Medicare payments, and improve quality, transitions, and other care aspects while reducing costs. Our Network is a group of persons experienced in healthcare delivery, operations, research, and advocacy, who join together to improve primary care models to make them more effective, efficient, and patient-centered for older adults, their families, and caregivers. One of us, Dr. David Dorr, met with Karen Fisher and Matt Kazan about the request, and we have provided this list of opportunities as well as our names and contact information for follow-up as needed. We **strongly** applaud your work here, the leadership of Senators Hatch and Wyden, and the work of all of the Senators and staff on the Finance Committee and those who contribute to this effort. Thank you for your service. We've organized the answers by each question.

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions

Research shows that those who serve as family caregivers to older adults report higher levels of stress and poorer health than the population at large. The stress of family caregiving for people with dementia can be especially burdensome. Dementia caregiving is associated with high emotional strain, poor physical house outcomes, and increased mortality. Primary care providers should ***routinely identify Medicare beneficiaries who are family caregivers*** as part of the Health Risk Assessment in Medicare's annual wellness visit. This would better track the beneficiary's health status and potential risks from caregiving, including physical strain, emotional stress, and depression.

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures

Older adults with chronic conditions face a number of barriers in terms of coping with their illness and optimizing their health, which include the lack of social support, low skill levels for symptom management, and low confidence in their abilities to manage their conditions (self-efficacy). Self-management is heralded as a key component in the improvement of health outcomes associated with chronic disease. According to the Institute of Medicine, self-management is defined as "the tasks that individuals must undertake to live well with one or more chronic conditions". There has been very little focus by health plans, including Medicare and Medicaid, on the role of the individual in proactively managing their health conditions and taking more responsibility for improving their personal behaviors that will result in improved health outcomes and lower costs.

We are urging the Chronic Care workgroup support for Medicare beneficiaries to have access to evidence based self-management programs for chronic disease, pain management, fall prevention and physical activity which will result in improved quality of care, improved disease management and lower per capita costs. In particular, we are asking for support to allow Medicare funding of the Stanford Chronic Disease Self Management Program (CDSMP), for older adults with chronic disease. CDSMP is one of the most well-known and researched evidence-based programs, is a good model for people with

MCCs, as research studies have demonstrated positive changes in self-efficacy, health behaviors, physical and psychological health status, and symptom management as well reducing per capita costs of health care with an approximate 2:1 return on investment in the first year as noted in a national study published in 2013. This equates to a potential net savings of $364 per participant and a national savings of $3.3 billion if 5% of adults with one or more chronic conditions are reached. These programs should be a patient-covered benefit provided to patients and integrated with care traditionally given by health care providers.

CDSMP and other evidence based programs can address a number of the areas you have asked for input on in the stakeholder letter.

- These programs will improve the health and quality of life for Medicare beneficiaries with multiple chronic conditions. For example, individuals are more likely to effectively use of their prescription drugs and understand their importance (policy category #4).

- There is an online version of the CDSMP which would allow use of technology to spread self-management strategies with broader reach.

- In addition, there is a tool kit for CDSMP for those living in rural and frontier areas that do not have access to the internet or community programs. Each one of these options has been shown to be effective in improving self-management skills (policy category #6).

- These programs are the best option for empowering Medicare patient to play a greater role in managing their health and meaningfully engaging with their health care providers (policy category #7).

- This will meet the goals of primary care providers and care coordination teams to maximize the health care outcomes for Medicare patients living with chronic conditions (policy category #2)

This approach allows for any person with chronic illness to attend a CDSMP program and can be recommended for all Medicare Advantage Programs, ACO Programs, CMS piloted alternate payment models (APMs) and Patient Centered Medical Homes to make these programs available to their population with chronic disease.

3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

Creation of a flexible, multi-payer waiver and demonstration application template with accompanying guidance encouraging interested health care and social services providers to apply to CMS to create integrated service delivery systems within communities in order to serve eligible frail elderly Medicare beneficiaries (including dual eligibles) who require a mix of closely coordinated medical and LTC services.

<u>Two variants</u>:

1. A capitation model, with PMPM payments up front provided to the community plan from Medicare, or Medicare and Medicaid for duals, along with a requirement to meet certain quality metrics as negotiated with and approved by CMS. Savings would be required to be directed to buttressing community-based supports and services to meet the assessed needs of this population (especially those

that would otherwise likely not be provided due to underfunding of social services and supports through the Older Americans Act and related state and local programs) and for ongoing operations.

2. A shared savings model (modified ACO) option, with benchmarked spending projections calculated and approved by the community plan and by CMS; at the end of each year a reconciliation would be conducted and actual spending, as well as quality performance (against metrics negotiated with and approved by CMS) would be compared with benchmark projected spending. The difference between the benchmarked projected spending and actual spending would comprise the savings. This amount would then be provided to the plan, which would be allowed to keep all but a percentage of the savings retained for the Medicare trust fund. Savings would be required to be directed to buttressing community-based supports and services to meet the assessed needs of this population (especially those that would otherwise likely not be provided due to underfunding of social services and supports through the Older Americans Act and related state and local programs) and for ongoing operations.

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology
6. Strategies to increase chronic care coordination in rural and frontier areas

We've combined these two requests.

Telehealth and remote monitoring technology has a mixed evidence-base, yet there is obvious opportunity to decrease the distance between remote patients, caregivers, and providers using this technology. Our first suggestion is to use the technology to engage health care professional peers to learn from each other. Rural and frontier communities are isolated from others, yet technology can help connect peers to each other. Our specific suggestion has 3 particulars:

1) When a new care coordination code or initiative is enacted, technical assistance must provide peer assistance for rural and frontier practiecs through learning collaboratives using technology.
2) These initiatives must encourage rural providers specifically to engage, give them additional encouragement, and allow them to connect virtually with peers to learn how to make the new initiative work in their settings.
3) The Inspector General should be encouraged to give specific latitude to these groups to allow them to try out the coding systems without significant concern for fraud and abuse during the trial period.

An example for this would be the Chronic Care Management code, recently enacted by CMS. To successfully enact this code, rural and frontier providers might need a significant amount of infrastructure compared to their current coding and billing approach. For instance, they'll need to switch to monitoring telephone calls and other outreach mechanisms, put into place registries for persons who might be eligible and those who have accepted the CCM services, and regular reporting to assist in fulfilling expectations and actually submitting payment. Discussing the most effective and efficient ways to adopt this infrastructure with peers who have similar issues has been shown to be helpful in several studies.

In addition, as noted above, there are both online tools and self-management tool kit from CDSMP for those living in rural and frontier areas that do not have access to the internet or community programs. These options have been shown to be effective in improving self-management skills.

7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

The most effective way to engage older adults with multiple morbidities is to focus on outcomes of interest to patients (function, quality of life, reducing symptom burden, avoiding disability, reducing psychological distress, etc.). Reimburse for outcomes rather than discrete services, treatments, or diagnoses. Let patients decide which of these outcomes is most important to them (i.e., patient-driven goals), and then expect that health care providers will implement services to achieve those goals most efficiently, safely, and effectively. Reimburse not for service provided but rather the outcomes obtained. Reimburse at both patient and population levels to reduce cherry-picking of healthier patients while still making providers and systems accountable to people and not numbers or metrics. Let patients have a say in determining if outcomes are met using patient-reported outcome measures rather than only biomedical markers or tests. This will make services both safer and more patient-centered. Focusing reimbursement on patient driven goals and patient-reported outcomes will also rationalize costs of services because prices will be better aligned with actual costs. Furthermore costs will become more transparent to ensure clearer alignment with patient driven goals.

8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions

Medicare beneficiaries benefit from the Annual Wellness Visit (AWV) focus on identifying problems that adversely affect the health outcomes and quality of life of older adults but the evidence based interventions are not uniformly available to primary care teams. Research demonstrates that these clinically important conditions, called the geriatric syndromes, lead to declining overall health with concomitant rise in healthcare costs and life dissatisfaction. As personal chronic disease burden rises, management of the geriatric syndromes becomes increasingly important. Managing these syndromes is most often the first step in the evidence based guidelines for most chronic disease management strategies. Primary Care teams often do not have the resources themselves to develop evidence based interventions in each area, i.e., falls prevention, physical activity guidance, memory loss, self-management of chronic diseases, or pain management programs. Home and Community Based Service partnerships can help fill this gap. Effective screening, assessment and management of the geriatric syndromes, coordinated through primary care teams across the continuum of care and with strategic community partnerships has been clearly shown to improve healthcare outcomes and personal life satisfaction while decreasing Medicare costs.

Contributing Members:

David Dorr, MD, MS
Associate Professor and Vice Chair
Medical Informatics and Clinical Epidemiology
Oregon Health & Science University
[redacted]

Bio: Dr. Dorr's interests lie in complex care management, especially for older adults and other at-risk populations, coordination of care, collaborative care, chronic disease management, quality, and the requirements of clinical information systems to support these areas. From these interests, he has broadened into clinical information needs, Electronic Health Record (EHR) deployment and Health

Information Exchange as a way to expand systems-based approaches to all of health care. Finally, David performs evaluations of care management and informatics initiatives using a variety of methodologies.

Christine (Himes) Fordyce, MD
Group Health Physicians
[redacted]

Bio: Dr. Fordyce has been a primary care physician with a focus on older adults at Group Health in Seattle for 30 years. Since 1992 she has held numerous leadership positions in geriatrics including Medical Director of Geriatrics and Long Term Care and Medicare Medical Director. She has been at the front lines of the transition to one of the early Patient Centered Medical Homes and works closely with the Group Health Senior Caucus, helping ensure consumer participation in the creation of patient centered healthcare models.

Robyn L. Golden, MA, LCSW
Director of Population Health and Aging / Masters in Social Work
Rush University Medical Center
[redacted]

Bio: Ms. Golden is a social worker and Director of Population Health and Aging at Rush University Medical Center. Her areas of expertise include improving care coordination and care transitions for patients with complex chronic conditions.

Aanand D. Naik, MD
Associate Professor of Medicine
Baylor College of Medicine
Houston Center for Innovations in Quality, Effectiveness, and Safety
[redacted]

Bio: Dr. Naik is a medical geriatrician and health outcomes researcher. His work and expertise focus on redesigning systems of care to improve patient engagement and care coordination to reduce medical morbidity, improve functional outcomes, and reduce harms associated with health care services.

Rob Schreiber, MD, CMD
[redacted]

Bio: Dr. Schreiber is a practicing Geriatrician and Internist with a focus on care of frail elders for over 30 years and serves as a faculty member of the Beth Israel Deaconess Medical Center, Harvard Medical School and Hebrew SeniorLife in Boston, MA. He works as a geriatric consultant in a Patient Centered Medical Home for an Accountable Care Organization to develop a systems approach to managing the high risk elder population and involves and interdisciplinary team including the patient and family, community based organizations and other disciplines. He is also Medical Director of Evidence based Programs for the Massachusetts's Healthy Living Center of Excellence (www.healthylving4me.org) which helps individuals take self responsibility managing chronic disease through a number of evidence based community programs that have been shown to improve health, healthcare and lower cost. He is also Medical Director of a community based care transitions program working with an Area Agency of Aging to prevent readmissions, improve care coordination and which has involved working with dual eligible plans and hospital quality improvement. He is also a CMS advisor for the national QIO-QIN network on diabetes self-management programs.

This is submitted on behalf of the Patient-Centered Medical Home for Older Adults Change AGEnts Network by the co-chairs. The Network would be happy to be engaged to answer specific questions as they arise in the areas above.

Signed,

David Dorr
PCMH Network Co-Chair

Rob Schreiber
PCMH Network Co-Chair